

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

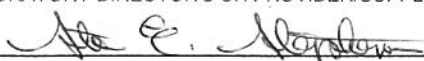
PRINTED: 01/20/2012
FORM APPROVED
OMB NO. 0938-0391

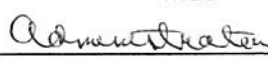
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER BROOKWOOD NURSING CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 203 SS=D	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for</p>	F 203	<p>This plan of correction is our credible allegation of compliance.</p> <p>"Preparation and/or execution of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law."</p> <p>F 203 Notice Requirements Before Transfer/Discharge</p> <p>What corrective actions(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</p> <ol style="list-style-type: none"> 1. The resident in question was actually technically discharged as family insisted on taking him out of the facility for several days to attend Dr. appointments in central Tennessee. At the time family took him out the facility census was below 85% and he would have not been covered by Medicaid bed hold even if he had been 		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE





2.2.12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 203	<p>Continued From page 1</p> <p>nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility business office documentation, medical record review, and interview, the facility failed to include the required elements in a notice of discharge for one resident (#2) of three sampled residents.</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on June 9, 2010, with diagnoses including Chronic Obstructive Pulmonary Disease and Dysphagia.</p> <p>Review of a "Certificate of Facility" dated August 30, 2011, provided by the facility on January 17, 2012, revealed, "... (resident) has been paying an amount that we understand equals (resident's) patient liability as if...receiving Medicaid...\$290.15 per month...At this time...owes our facility over \$50,000...Unless (resident) can pay us for the services we have previously rendered...no later than September 30, 2011, we will be forced to take action to discharge...for non payment..."</p>	F 203	<p>eligible for Medicaid, which he wasn't as he had been denied Medicaid and his appeal of said denial had also been denied. The resident was not allowed to readmit as he owed the facility over \$60,000 upon discharge that the family had continually refused to pay.</p> <p>How will you identify other residents having the potential to be affected by the same alleged deficient practice(s) and what corrective action will be taken:</p> <ol style="list-style-type: none"> 1. Any resident transferring or being discharged from the facility has the potential to be affected by the alleged deficient practice. <p>What measures will be put into place or what systematic changes you will make to ensure that the alleged deficient practice(s) does/do not reoccur:</p> <ol style="list-style-type: none"> 1. Nursing inservice began January 17, 2012 regarding proper documentation upon resident transfer/discharge from the facility. 2. The notification of bed hold that goes out with all 		

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F 203	<p>Continued From page 2</p> <p>Continued review revealed the notice did not include to whom the notice was addressed, the right to appeal, or the name, address, and telephone number of the State Long Term Care Ombudsman.</p> <p>Interview with the administrator on January 17, 2012, at approximately 2:00 p.m., in his office, revealed the "Certificate of Facility" dated August 30, 2011, was the facility's thirty day notice of intent to discharge the resident.</p> <p>Review of a State of Tennessee Department of Human Services (DHS) Division of Appeals and Hearing Initial Order dated January 7, 2011, provided by the facility on January 17, 2012, revealed persons present for the hearing included Estate Planner #1.</p> <p>Review of a Facsimile Transmittal Sheet dated September 2, 2011, revealed the facility sent unidentified information to Estate Planner #1.</p> <p>Interview with the administrator on January 17, 2012, at approximately 2:00 p.m., in his office, revealed the facility's "Certificate of Facility" (notice of intent to discharge the resident) was sent to Estate Planner #1 at the request of the resident's responsible party (the resident's son).</p> <p>Medical record review of a nurse's note dated October 9, 2011, revealed the resident left the facility with the resident's daughter and son-in-law, and included, "...stable upon exit..." Medical record review of a discharge summary dated October 9, 2011, revealed, "...date of discharge 10-9-11..." Medical record review revealed no documentation regarding the reason</p>	F 203	<p>transferring/discharged residents was modified on February 1, 2012.</p> <p>3. Any notice of intent to discharge a resident will be forwarded to appropriate/required entities.</p> <p>How the corrective action(s) will be monitored to ensure the alleged deficient practice(s) will not reoccur; i.e. what assurance program will be put into place:</p> <ol style="list-style-type: none"> 1. Medical records will be reviewed by DON or designee for proper documentation when a resident transfers or discharges from the facility. 2. Social Services notes and financial folders of each transferred/discharged resident will be reviewed within two business days by the Administrator designee to ensure proper documentation is in place. 3. Results of medical record, social service notes and financial folder reviews will be reported at QA meetings for three months. If no deficiencies are discovered in these three months, routine 	<p>2.1.12</p> <p>2.6.12</p> <p>2.6.12</p> <p>2.6.12</p>	

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F 203	Continued From page 3 for the resident's involuntary discharge. Interview with the administrator on January 17, 2011, at approximately 2:00 p.m., in the administrator's office, confirmed the facility failed to include the required elements of a notice of involuntary discharge for Resident #2, and failed to document the reason for the resident's discharge in the resident's medical record. C/O: #29136	F 203	checks of these records will be discontinued.	2.24.12
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IN-SERVICE TRAINING REPORT

(PERSONNEL ATTENDANCE RECORD ON REVERSE)

Facility Brookwood Department: Nursing

Date 11/12/12 From: _____ To: _____

Employee group(s) present: Lic. Nurses

Topic Documentation, Resident Discharge, Skilled Documentation, Admission Orders

Contents or summary of training session (if related to OSHA standard bloodborne pathogens training indicate "See Below" and use the convenient check-off list below):

Nursing documentation, Skilled documentation, Admission and Discharge Process and documentation. Discharge Checklist in place. POST form completion.

OSHA standard bloodborne training requirements. Check those topics covered. Use space above to clarify.

- ☐ Explanation of regs (1910.1030)
- ☐ Epidemiology & symptoms
- ☐ Modes of transmission
- ☐ Exposure control plan
- ☐ Recognizing tasks/activities that pose risk or risk potential

- ☐ Methods to prevent/reduce exposure
 - ☐ Engineering controls
 - ☐ Work practices
 - ☐ Protective equipment
- ☐ Personal protective equipment (must include types, use, removal, handling, decontamination, disposal, & selection)
- ☐ Hepatitis B vaccine

- ☐ Reporting and responding to exposure occurrences, employer post-exposure evaluation and follow-up responsibilities
- ☐ Signs & labels and/or color coding used to identify equipment used to store or transport blood or potentially infectious material

Conducted by: _____
Name(s), Title(s) and Qualification(s)

Evaluation, comments, suggestions: _____

Signature of person completing report: D. Davis RN Title: Don.

IN-SERVICE TRAINING REPORT

(PERSONNEL ATTENDANCE RECORD ON REVERSE)

Facility Brookwood Department: Nurses

Date 2.1.12 From: Steve Steph To: _____

Employee group(s) present: _____

Topic Infectious Disease notification

Contents or summary of training session (if related to OSHA standard bloodborne pathogens training indicate "See Below" and use the convenient check-off list below):

The attached form should be given to all residents leaving the facility either to Dr. appts, hospital, or out of family

OSHA standard bloodborne training requirements. Check those topics covered. Use space above to clarify.

- | | | |
|--|---|--|
| <input type="checkbox"/> Explanation of regs (1910.1030) | <input type="checkbox"/> Methods to prevent/reduce exposure
<input type="checkbox"/> Engineering controls <input type="checkbox"/> Work practices
<input type="checkbox"/> Protective equipment | <input type="checkbox"/> Reporting and responding to exposure occurrences, employer post-exposure evaluation and follow-up responsibilities |
| <input type="checkbox"/> Epidemiology & symptoms | <input type="checkbox"/> Personal protective equipment (must include types, use, removal, handling, decontamination, disposal, & selection) | <input type="checkbox"/> Signs & labels and/or color coding used to identify equipment used to store or transport blood or potentially infectious material |
| <input type="checkbox"/> Modes of transmission | <input type="checkbox"/> Hepatitis B vaccine | |
| <input type="checkbox"/> Exposure control plan | | |
| <input type="checkbox"/> Recognizing tasks/activities that pose risk or risk potential | | |

Conducted by: _____ Name(s), Title(s) and Qualification(s)

Evaluation, comments, suggestions: _____

Signature of person completing report: _____ Title: _____

BROOKEWOOD NURSING CENTER

332 River Road

Decatur, TN 37322

Phone: 423-334-3002

Fax: 423-334-5591

On _____ (date), Mr. /Mrs. _____ is being transferred to the hospital for care or is leaving the facility with family. If he/she is out of the facility beyond midnight we will be required to discharge him/her from our facility. If your payer source is Medicaid they will pay to hold the bed for 10 calendar days per year. Note that in order for Medicaid to pay for bed hold, the facility census must be at 85%. If you have any questions about whether or not your bed hold is covered by Medicaid please call our Business Manager. If your payer source is another insurance or if you are private pay you will need to make arrangements to hold their bed.

If you should wish to hold their bed here at Brookewood, please call our Business Office Manager or Administrator to make arrangements to pay the private pay bed hold rate of \$140 per day.

If you choose NOT to hold the bed, _____ (name) will be placed on our waiting list and can be readmitted upon discharge from the hospital pending bed availability, our ability to meet care requirements, and resident private account balance is current or brought current.

If you have any further questions, please feel free to contact our office for further explanation.

Thank you,



Steve Stephens

Administrator

Brookewood Nursing Center

423-334-3002